VERMONT
DEPARTMENT OF HEALTH
Agency of Human Services

STATE OF VERMONT
PROJECT CRASH
RELEASE OF
CONFIDENTIAL INFORMATION

I,_____, date of birth: ___/___/___, authorize Project CRASH to disclose information about the facts of my enrollment, current status, and completion of the Project CRASH School/therapy program to, and to obtain information to assist in determining completion of the Project CRASH School/therapy program from:

The Vermont Department of Motor Vehicles,
The Vermont Department of Corrections, including Probation & Parole,
Applicable Vermont District or Superior Court(s),
Court Diversion and/or Teen Alcohol Safety Program

Please check any additional agencies/persons to whom information may be disclosed and received:

- ❑ Spouse and/or other family member (MUST list names) _____
- ❑ Attorney (MUST give name or agency) _____
- ❑ Department of Motor Vehicles in a State other than Vermont (MUST give department and address)_____
- ❑ Counselor/Treatment facility (MUST give name of facility and/or counselor)_____ _____
- ❑ Other agency or person _____

The purpose of the disclosure authorized herein is to:

Satisfy the conditions of my probation/parole and/or
Satisfy conditions for the reinstatement of my driving privileges and/or
Other _____.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 C.F.R. part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically upon my release from probation/parole and/or upon reinstatement of my driving privileges.

Signature of Participant: _____ Date: _____

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